HIGHLAND HOSPITAL
STRONG MEMORIAL HOSPITAL

☐ Inpatient
☐ Outpatient
☐ ED

[redacted]

SH 402 MR
Page 1 of 2

DO NOT USE ABBREVIATIONS: U, IU, QD, QOD, Trailing zero (X 0 mg), Lack of leading zero (X mg), MS, MSO_4, $MgSO_4$, µg, TIW, AS, AD, AU

Document Date and Time of Each Note

DATE	TIME	AM PM	
10/20/2010	1410		ED Attending
			Vighay kwan with the Circus as the elephant handler. For 2+ days has had an excruciating right retro-orbital h/a with hypersensitivity to right temple
			⊖ fever, chills, visual Δ's
			⊖ N/V
			Has no PMH including hx of headaches
			PE normal except for possible ↓ abduction right eye.
			Attempted trials of PO meds and then IV analgesics ō good effect
			CT scan → enlarged right ventricle.
			Neuro consulted who recommends we admit for pain control and MRI in AM.
			[redacted]

Rev 2/05

HIGHLAND HOSPITAL
STRONG MEMORIAL HOSPITAL

☒ ED

[redacted]

EMERGENCY DEPARTMENT PHYSICIAN ASSESSMENT & TREATMENT SHEET

SH 400P MR

Date/Time 10/26/10 9:17

Attending/Resident/Student/PA/NP Name (printed) [redacted]
Attending/Resident/Student/PA/NP Name (printed)

History of Present Illness Brief 1-3 Extended 4+

VS T 36.9 RR 16 P 70 lying BP 126/85 lying Pulse Oximetry 97
☐ Vitals on Triage sheet reviewed P ___ sitting BP ___ sitting Wt 95.3 kg
P ___ standing BP ___ standing Pain (0-10) 8

Chief Complaint **Medical Student Note**

25 yo male c̄ reports of bad head aches since Friday. Headache over right eye intermittent sharp pain on temple, otherwise constant HA

Rarely gets headaches

Took Ibuprofen & Tylenol w/o relief.

Hurts to rub hand over area. No n/v/ no sensitivity to light. No auras. Mom has migraines

☐ Location
☐ Severity
☐ Quality
☐ Duration
☐ Timing
☐ Context
☐ Modifying Factors
☐ Assoc Signs/Symptoms
☐ Comprehensive Hx unobtainable due to patient's clinical condition and/or mental status
☐ Nursing/Triage notes reviewed, Emergency Medical Services report, family, EKG, old records, Other ___

ALLERGIES/REACTIONS ☐ None
Latex allergy/sensitivity ☐ Yes ☑ No
Food allergies ☐ Yes ☑ No
Other known allergies ☑ Yes ☐ No Bees
If yes, specify allergen & type of reaction

MEDICATIONS/OVER-THE-COUNTER/HERBALS/VITAMINS/SUPPLEMENTS
☑ None ☐ See attached sheet
☐ Listed ☐ See triage sheet
None

Past Medical / Surgical / Family / Social / Occupational History Complete 3

Past History ☐ None
☐ Diabetes ☐ Heart Disease
☐ Renal ☐ Hypertension
☐ Seizures ☐ Asthma/COPD
☐ DVT/Pulmonary Embolism
☐ Cancer
☐ Surgery Appendix/(Gall Bladder)/CABG
☐ Other

Family History ☐ None
☐ Diabetes ☑ Heart Disease MI father, GF father
☐ Renal ☐ Hypertension
☐ Seizures ☐ Asthma/COPD
☐ DVT/Pulmonary Embolism
☐ Cancer GF - GM BCA
☐ Surgery Appendix/Gall Bladder/CABG
☐ Other migraines (mother)

Social History

	None	Current - Amount	Quit - Date
Tobacco	✓		
ETOH		occasional 1-2 week	
Drugs	✓		

Work Elephant handler c̄ circus
Home
Domestic Violence

Advance Directive(s) ☐ Yes ☐ No If Yes, type ☐ DNR ☐ Health Care Proxy ☐ Living Will ☐ Other ___ If No, does pt want to designate a Health Care Proxy? ☐ Yes ☐ No
Comments

Review of Systems Problem Pertinent 1 Extended 2-9 Complete 10+

	Normal	Abnormal			Normal	Abnormal			Normal	Abnormal	
General	☑	☐		GI	☑	☐		Endocrinologic	☑	☐	
Eyes	☑	☐		GU	☑	☐		Allergy/Rheumatology	☑	☐	
HENT	☑	☐		Skin	☑	☐		Neurologic	☑	☐	
Cardiovascular	☑	☐		Musculoskeletal	☑	☐		Psychiatric	☑	☐	
Pulmonary	☐	☑	Dusty air since ___	Hematologic/Lymphatic	☑	☐		☐ All other systems reviewed and negative			

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[redacted]

EMERGENCY DEPARTMENT PHYSICIAN ASSESSMENT & TREATMENT SHEET

SH 400P MR

EXAMINATION OF SYSTEMS Problem Focused 1 Extended Problem Focused 2-4 Detailed 5-7 Comprehensive 8+

PHYSICAL EXAM by ☐ Attending ☑ Resident ☐ PA/NP DATE 10/26/10

EXAM LIST

☐ Comprehensive examination not completed due to patient's clinical condition and/or mental status ______

	Normal	Abnormal (specify)	
Constitutional			
general appearance	☑	☐	c̄ [illegible]
Eyes			
conjunctivae & lids	☐	☐	20/20 RE
pupils & iris	☑	☐	20/25 LE
EOM	☐	☑	cannot adduct (L) eye
Head, Ears, Nose & Throat (HENT)			
ears	☐	☐	
otoscopic	☐	☐	
hearing	☑	☐	
nose	☐	☐	
oropharynx	☑	☐	
lips, teeth, gums	☑	☐	
voice	☑	☐	
fontanelles	☐	☐	
trauma	☐	☐	
supple	☑	☐	
tenderness	☐	☐	
jugular vein distension/bruit	☐	☐	
Cardiovascular			
palpation	☑	☐	
auscultation	☑	☐	
carotids	☐	☐	
abdominal aorta	☐	☐	
femorals	☐	☐	
pedal pulses	☑	☐	
edema & varicosities	☐	☐	
Pulmonary			
respiratory effort	☑	☐	
auscultation	☑	☐	
percussion	☐	☐	
inspection/palpation	☐	☐	
Gastrointestinal/Abdomen			
tenderness	☑	☐	
bowel sounds	☑	☐	
masses/pulsations	☐	☐	
hernia exam	☐	☐	
rectum	☐	☐	

	Normal	Abnormal (specify)	
Genitourinary			deferred
urethra	☐	☐	
bladder	☐	☐	
scrotum/testes	☐	☐	
penis	☐	☐	
prostate	☐	☐	
external genitalia	☐	☐	
cervix	☐	☐	
uterus	☐	☐	
adnexa	☐	☐	
Skin			
color	☑	☐	
temperature	☑	☐	
lesions	☐	☐	
Musculoskeletal			
digits & nails	☑	☐	
spine	☐	☐	
pelvis	☐	☐	
Right Upper Extremity	☑	☐	
Left Upper Extremity	☑	☐	
Right Lower Extremity	☑	☐	
Left Lower Extremity	☑	☐	
Hematologic, Lymphatic, Immunologic			
neck	☑	☐	
axillae	☐	☐	
groin	☐	☐	
thyroid	☐	☐	
Neurologic			
cranial nerves	☑	☐	grossly NL
DTR's	☐	☐	
gait & station	☐	☐	
motor	☑	☐	
sensation	☑	☐	
Psychiatric			
judgement	☑	☐	
orientation	☑	☐	
memory	☑	☐	
mood / affect	☑	☐	

Comments

Hemoccult	Cultures Sent
☐ Positive ☐ Negative	☐ GC
Control Test	☐ Chlamydia
☐ Positive ☐ Negative	☐ Other ______

Medical Decision Making (# possible dx / mgmt options, amount, complexity of info, risk of complications &/or morbidity / mortality)

Assessment / Problems

25 yo male c̄ (R) sided headache x 4 days (+) intermittent (+) [illegible] c/o relief from ibuprofen

☐ See attached supplemental procedure note(s)

Plan

- ESR
- Compazine
- CT head
- Dilaudid
- Neuro consult

Differential Diagnoses

migraine headache vs cluster headache vs arteritis vs vasculitis

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EMERGENCY DEPARTMENT PHYSICIAN ASSESSMENT & TREATMENT SHEET

SH 400P MR

Teaching Physician Note:

Time _____

History ☐ I interviewed this patient, reviewed the resident/fellow/PA/NP note, and agree with or correct the findings as below

History notable for _____

Exam ☐ I examined this patient, reviewed the resident/fellow/PA/NP note, and agree with or correct the findings as below

Physical Exam is notable for _____

See progress note.

Decision Making ☐ I discussed and agree with or correct the documented resident/fellow/PA/NP decision making as below

X-ray images / tracings / lab specimens

☐ Personally reviewed by me ☐ I discussed with performing/interpreting MD

Follow Up Notes / Procedure Date Time

I, as Attending, was present for the key portions of these procedures

☐ See supplemental procedure note(s)

☐

☐

Total Critical Care Time _____ min Laceration Length _____ cm

All other billable procedures and teaching time not included in critical care time

Lab Results ☐ see printout

WBC / Hgb / Hct / Platelet

Segs _____ Lymphs _____

Bands _____ Mono _____

Na 140 | Cl 103 | BUN 28 / Glu 99

K 4.5 | CO2 25 | Cr .96

PT _____ INR _____

PTT _____ Alb _____

Ca 9.5 T Bil _____

Mg _____ D Bil _____

Phos _____ AST _____

LD _____ ALT _____

CK/MB _____ ALK _____

Amylase _____ ESR 2

Troponin ☐ < 0.01 _____

Lipase _____ Protein _____

D-dimer _____ BNP _____

Other _____ _____

_____ _____

ABG _____

UA _____

Urine Pregnancy + −

12-lead EKG NSR ☐

_____

CT head / abdomen / chest _____

_____

X-ray _____

_____

NOTIFICATIONS Called / Answered or Arrived at Comments

☐ PCP Notified ____/____ _____

☐ Consults (service) ____/____ _____

☐ Admitting MD Notified ____/____ _____

☐ Signed out to _____ at _____ _____

☐ Continued on additional page

☐ Tests / Procedures ordered, results pending

ED DIAGNOSIS: headache

PA / NP (signature) _____ ☐ Direct PA / NP Bill

Resident (signature) _____ Presented to ED Attending (name)/date _____

Attending (signature) _____ Dictation # _____

HIGHLAND HOSPITAL

ED NURSING DOCUMENTATION

HH 10993 MR

(L4) [redacted]

WEST 7

Date [illegible] Time 2152 | Code Status ☑ Full ☐ DNR/DNI ☐ ____
Chief Complaint Headache HA | Allergies ☑ NKA ☐ Latex ☐ Shellfish ☐ other
Admit DX Migraine headache Abnormal CT

HISTORY ☐ CVA ☐ Diabetes ☐ HTN ☐ COPD ☐ CHF ☐ MI
☐ Hyperlipidemia ☐ Seizure ☐ Psych ☐ Renal
☐ DVT / Pulmonary Embolism ☐ Appendectomy ☐ Stents
☐ CABG ☐ Cholecystectomy
☐ other No past medical Hx.

Labs. WBC ___ HCT ___ Troponin ___
Na+ 140 K+ 4.5 CR 0.96 BNP ___
BUN 28 WNL ___ Pending ___
Type & Screen ☐ Y ☐ N Other ___
BG ___ Time ___ (in hour of transfer)

Initial Vitals Time 0906 BP 124/[illegible] Pulse 70 T 36.8 RR 18 O_2 Sat 97 RA sed rate 2
Transfer Vitals Time 2200 BP 149/77 Pulse 85 T 36.9 RR 16 O_2 Sat 99 RA Pain 6
Pt Belongings ☐ Glasses ☐ Dentures ☐ Hearing aides ☑ Clothing ☐ Belongings home with family ☐ Assistive device ☐ Jewelry

MEDICATION RECORD

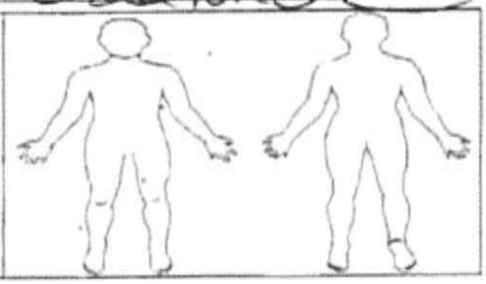
Time	BP / HR prior to cardiac medication	Medication	Dose	Route	IV amount	End time	BP / HR after cardiac medication	Site	Pain level	Nurse Initials	Reassess pain level/time
[illegible]	/	[illegible]	[illegible]	PO			/		[illegible]	[illegible]	[illegible] / [illegible]
[illegible]	/	Percocet	I	PO			/		7/10	[illegible]	6/10 / 1125
1311	/	dilaudid	1mg	IV			/		6-7/10	[illegible]	[illegible] 1240
1317	/	phenergan	12.5mg	IV			/	[illegible]	1		
1830	/	Toradol	30mg	IV	100cc		/	head	1829	[illegible]	Sleeping
2225	/	Dilaudid	1mg	IVSS			/		8		/
		Phenergan	12.5mg	IVSS	100				8	[illegible]	

IV RECORD

Time	Device /size	Insert site	# of attempts	Amount	Solution/Blood	Rate	Amount infused	End Time	d/c Time	Site condition	INT
1305	18g	LH	1	[illegible]	[illegible]	[illegible]	1,000 NS		180	[illegible]	[illegible]
2200	18g			1,000	NS	150					

Precautions: ☑ Fall ☐ Skin integrity ☐ Suicide ☐ Seizure ☐ ETOH ☐ Aspiration ☐ Restraints ☐ OSA risk ☐ yes ☐ no
Isolation: ☐ MRSA ☐ VRE ☐ C- Difficile ☐ Neutropenia ☐ Influenza ☐ Droplet
CARDIOVASCULAR: EKG Rhythm ☐ NSR ☐ Paced ☐ Other ___
Telemetry Ordered ☐ Yes ☐ No
MENTAL STATUS ☑ alert ☑ oriented ☐ disoriented ☐ confused ☐ agitated/combative ☐ lethargic ☐ unresponsive
RESPIRATORY: oxygen ☐ yes ☑ no ___ liters/min ☐ nasal cannula ☐ NRB ☐ venti mask ___% other
GI/GU: NPO since ___ ☐ Dysphagia screen ☐ yes ☐ no ☐ NG ☐ Feeding tube ☐ Stoma ☐ Foley ☐ Continen[redacted]
Other pertinent information pt ate @ 2200 Boxed lunch

Skin Integrity
☑ intact ☐ warm ☐ dry ☐ diaphoretic ☐ pale ☐ cool
Wound type
A Ulcer B Skin tear
C Incision D Redness
E Bruising F Laceration
G Rash
Surface where found prior to arrival
☐ unknown ☐ floor ☐ other ___
Wound Care Nurse Notified Date/Time ___ ☐ N/A



Orders ☐ Transition Orders ☐ Orders in CPOE
Pending tests and procedures ___

Other Relevant Medical Information
Nurse Signature [redacted]
Transported by

HIGHLAND HOSPITAL

[redacted]

ED NURSING DOCUMENTATION

HH 10993 MR

TRANSFER SUMMARY ACCEPTANCE NOTE

Date 10-26-10 Time 2330
Vital Signs BP 146/90 HR 58 O_2 Sat 97 O_2 Type RA T 37.1
☐ IV Pump Settings reviewed/changed by _____ ☒ N/A

DIABETIC PATIENT FSBG —

Pt arrived to W7 via stretcher. Pt a;ox3, VSS. Pt oriented to room; call bell system. Pts neuro ✓ upon arrival. Will continue to monitor.

_____ Signature [redacted]

** REVIEW/COMPLETE ADMISSION RISK ASSESSMEN[redacted]
(Update and record Braden Score/Fall Risk and other pertinent assessment that may have changed as a result of having a surgical procedure)
☐ Initiate identified consult needs

TELEMETRY STRIP (if applicable)

TRANSFER DETAILS
BELONGINGS WITH PATIENT ☐ Glasses ☐ Dentures ☐ Hearing Aides ☐ Clothing ☐ Belongings sent home with family ☐ C-PAP machine ☐ other items

☐ Medications sent with patient (refrigerated, patient's own, inhalers, non-Pyxis bin medications)

PATIENT/FAMILY CONCERNS

HIGHLAND HOSPITAL
PRIMARY

[redacted]

Patient Data

[redacted]

Complaint: Headache
Triage Time: Tue Oct 26, 2010 09:10
Urgency: 3–Green
Bed: ED ZONE–C
Initial Vital Signs: 10/26/2010 09:06
BP: 126/85
P: 70
O2 sat: 97 on ra
R: 16
T: 36.8
Pain: 8

KNOWN ALLERGIES
Denies

CURRENT MEDICATIONS
Pt Denies

VITAL SIGNS
VITAL SIGNS BP 126/85, Pulse 70, Resp 16, Temp 36.8, Pain 8, O2 sat 97 on ra, Time 10/26/2010 09:06

BP 140/81, Pulse 60, Resp 18, Temp 36.6, Pain 7, O2 sat 99 on ra, Time 10/26/2010 12:04

BP 145/73, Pulse 60, Resp 17, Temp 36.9, Pain 8, O2 sat 100 on RA, Time 10/26/2010 13:21

BP 148/91, Pulse 67, Resp 17, Temp 36.7, Pain 8, O2 sat 100 on ra, Time 10/26/2010 18:15

BP 147/76, Pulse 49, Resp 18, Temp 37, O2 sat 100 on ra, Time 10/26/2010 22:29

DIAGNOSIS
FINAL PRIMARY **Migraine headache**
PRIMARY **Migraine headache**, ADDITIONAL **abnormal CT scan**

TRIAGE
COMPLAINT Headache

[redacted]

ADMISSION URGENCY 3–Green , ADMISSION SOURCE Home , TRANSPORT Ambulatory , DEPT Emergency, BED ZZ–WAIT

[redacted]

PRE–TRIAGE NOTES Sharp Pain/Headache
HISTORY OF ILLNESS **R sided sharp head pain since Friday 10/22. Denies n/v but report being warm but no chills.**
COMMUNICABLE DISEASE Patient denies fever
FALLS RISK STATUS Risk Level I, Ambulates independently without assistive device(s), Any visual or auditory deficits are corrected, Able to bathe independently, Demonstrates ability and willingness to call for assistance, No risk factors related to medication regimen
INFORMATION SOURCE Patient
INTERVENTIONS PRIOR TO ARRIVAL None
TREATMENTS IN TRIAGE No Treatments in Triage
RESPIRATORY ASSESSMENT Easy

Highland Hospital
EMERGENCY FLOW SHEET RECORD
Name: [redacted]

VITAL SIGNS	DW12	RS07	RS07	RS07	BC01
TIME	10/26/2010 22 29	10/26/2010 18 15	10/26/2010 13 21	10/26/2010 12 04	10/26/2010 09 06
BP	147/76	148/91	145/73	140/81	126/85
PULSE	49	67	60	60	70
RESP	18	17	17	18	16
TEMP	37	36 7	36 9	36 6	36 8
PAIN		8	8	7	8
O2 SAT	100 on ra	100 on ra	100 on RA	99 on ra	97 on ra

[redacted]

HIGHLAND HOSPITAL
MEDICATION

[redacted]

KNOWN ALLERGIES
Denies

CURRENT MEDICATIONS
Pt Denies

PRESCRIPTION
No recorded prescriptions

GREET
GREET Greet Tue Oct 26, 2010 08:59

[redacted]